STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

# Authorization for Release of Health Information - Retirees

Retiree Name: _____

Retiree Dependent Name: _____

Address: _____

_____

Telephone #: ( ) _____ - _____ SS#: _____ - ____ - _____

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:
**State of Arkansas - Employee Benefits Division**

The type and amount of information to be used or disclosed is as follows:
(check off appropriate item(s), and include other information, where indicated)

Retirement Department

❒ billing issues related to health or life premiums
❒ life insurance coverage
❒ medical insurance coverage
❒ Medicare information
❒ other: _____

Medical Compliance Department

❒ medical claim issues
❒ pharmacy claim issues
❒ medication list
❒ list of medical problems
❒ list of your medications
❒ medical records from your physician or specialist
❒ medical records from hospitalization
❒ other: _____
❒ Do you have any allergies? If so, please list: _____
_____

This information may be disclosed to, and used by, the following individuals or organizations: *(providers, spouse, friends, etc.)*

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

**See reverse side.**

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

**By my signature below, I authorize disclosures to and by EBD.**

This information is being disclosed for the following purpose:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EBD Privacy Officer (on the header address.) I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

**If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of this signing.**

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment enrollment in my health plan, or eligibility for benefits.

_____ _____

Signature of Retiree, Retiree Dependent or Legal Representative Date

_____

If signed by legal representative or dependent, print relationship to Retiree

_____ _____

Signature of Witness Date

I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

## Retain a copy for your records and forward a copy to EBD